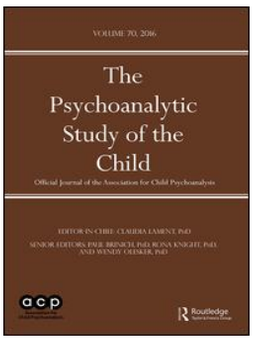

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DIAGNOSTIC PROFILES

A DIAGNOSTIC PROFILE OF PSYCHOPATHOLOGY IN A LATENCY CHILD

DALE R. MEERS

Foreword by Reginald S. Lourie, M.D.

The child presented in the Diagnostic Profile that follows has suffered from a seizure disorder for at least six years. This Profile is *not* intended as a differential assessment of an organic as contrasted with a hysterical dysfunction. The child continues under independent neurological supervision during his ongoing psychotherapeutic treatment.

The purposes of this paper would *not* be served if it were considered as an extension of the discussion of organic versus psychogenic etiology of epileptic or seizure disorders. However, at the present stage of the child's treatment (and continuing diagnostic assessment), it is essential to consider the nature of the convulsive disorder as it affected the boy's defense organization, ego capacities, and neurotic solutions to conflict. It is hoped that the treatment will clarify whether, or to what degree, neurosis has made use of a convulsive potential. If hysterical features were to emerge during treatment, if psychotherapy were to disclose a hysterical etiology (which might accompany an organic predisposition), such questions might eventually be examined in the light of analytic documentation.

Clinical experience has consistently underscored the desirability of psychotherapeutic help for many of the patients suffering from emotionally enhanced seizure disorders. In the present case, the

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psychopathological symptomatology might be ascribed, ultimately, to an organic seizure condition and a concomitant intolerance in the ego organization. The structure of both symptomatology and pathogenic defense organization, as evidenced in the following Profile, make it clear that the *form* of the disorder is that of a childhood neurosis which has moved toward encapsulation in a character disorder. That the origins of psychopathology may have roots in an organic impairment is hardly an irrelevant question. Quite the contrary. If true, organic dysfunction is an even stronger reason for psychotherapeutic intervention to help the child cope with atypical neurological dysfunction that complicates and burdens an overtaxed child who adapts by psychopathological means.

The merit of the Diagnostic Profile derives from the clarity of a conceptual biopsy, an ordering of symptoms and developmental data that are both complex and otherwise obscure in the wealth of usual historical and analytic detail. As an *illustration* of the utility of the Profile for the incisive assessment of complexities of childhood disorders, the following paper is a helpful clinical contribution, as is the Profile itself.

R. S. L.

The Research Origins of the Profile

There are four papers that form an indispensable background to the present paper and the use of the Profile in general. A summary of these papers would be an exhaustive commentary on psychoanalysis—and would also do gross disservice to theoretical and clinical formulations that are already concise and renowned for their clarity. The first of these is Anna Freud's classic "Indications for Child Analysis" (1945) in which she stressed the need for a change in emphasis from clinical considerations of manifest childhood symptomatology to an assessment of the impediments to the child's maturational progression. In that paper Anna Freud also discussed the appropriateness and timing, the essential need for diagnostic justification of psychoanalytic intervention in the child's life.

In "Assessment of Childhood Disturbances" (1962), Anna Freud continued and extended a number of formulations and considerations that lend themselves to effective diagnosis, based on the inte-

grated structure of a psychoanalytic "profile of development." A major subsection of the Profile was given more detailed explication in the following year with the publication of Anna Freud's "The Concept of Developmental Lines" (1963). These "lines" provide a specific frame of reference in the assessment of the complex differences, processes, and phases that (may) help differentiate relative normality from varied pathogenic manifestations in childhood.

Clinical and observational data have established that regressions or transient symptoms in particular phases (and ages) of childhood are not essentially pathogenic and that fixations are not unequivocal. Moreover, some expressions of evident and established childhood pathology (which indicate an inadequate resolution of childhood conflict) may be "bypassed" without impeding the mainstream of maturational forces available to the young ego. In Freud's (1916-1917) famous analogy, the question of fixation then involves assessing whether the maturational army had need to leave a regiment to guard against insurrection, or whether a patrol squad sufficed. The concept of "developmental lines" offers a particularly helpful and rewarding conceptual approach with which to evaluate the relative degrees of fixation, regression, or progression in the diagnostic exploration.

The "developmental lines" contain virtues that are not revealed at first blush. There is the explicit need for a diagnostic appraisal of the "age adequacy" of behaviors, defenses, etc. "Age adequacy" could be misunderstood as a static concept, particularly when behaviors (and their modes) reflect strong social and cultural pressures that facilitate (or impede) given drives or modes of their expression (e.g., in the expression of aggression or libidinal forms of gratification). The evaluation of the "age adequacy" of behaviors, i.e., in the context of "developmental lines," permits a bypassing of social and cultural preconceptions or misconceptions of "normalcy" and "pathology." The Profile requires a structured consideration of the ubiquitous processes of biology and psychology operating in all infants and their maturation. *Whatever* the direction or impact of social or cultural stress (manifest in parental-environmental nurture) on the infant and child, a "line of development" exists and permits assessment of its characteristics in that context. Among these universal "lines" are those that lead toward body independence, e.g., from

suckling to rational eating, from wetting and soiling to bladder and bowel control, from irresponsibility to responsibility in body management, etc. (A. Freud, 1963, 1965).

In discussing the use and development of the Profile, Nagera (1963) extended the rationale of its structure while providing the first published illustration. The adequacy of diagnosis is obviously not to be measured in the completion of subsections of a formula or Profile. Yet the inception and developmental structuring of the Profile, via prolonged diagnostic research at Hampstead, have "built in" a progression of considerations leading from developmental data to increasingly specific theoretical, metapsychological formulations of explicit diagnostic significance.

The problems of differential diagnosis of childhood disorders are obviously not resolved by the Profile, which is essentially a conceptual tool that can be used with varying degrees of adequacy, depending on the experience of the diagnostician. The Profile does, however, provide for a "fail-safe" (in the vernacular of the day) to the degree that the diagnostician must relate his clinical observations back to the structure of psychoanalytic, developmental metatheory. As Anna Freud has underscored in her most recent work, *Normality and Pathology in Childhood* (1965), the assessment of childhood disturbances continues to be complicated because, among other reasons, we know so little of "normal" variations of maturation.

It is of importance to restate the Hampstead staff's caution, in this regard, that the Profile was developed from the study of psychoneurotic conflicts of childhood, vis-à-vis (what is known of) "normal" ego-drive development. As a diagnostic research tool, the Profile has undergone significant internal modifications. It has been considered less a "finished product" than an experimental research tool designed for specific types of assessment.[1] The Profile's utility for assessments of other forms of pathology has been extended to adult neuroses (A. Freud, H. Nagera, and W. E. Freud, 1965), the study of impulse disorders (Michaels and Stiver, 1965), atypical and borderline children (Thomas et al., 1966), etc. Its value for teaching, with reference

[1] My own (limited) familiarity with Hampstead's Profile work derives from attending Diagnostic and Profile Research Committee Meetings during my last two years of training there.

to both analytic diagnosis and conceptualization, seems to have very rich but still undocumented or unexplored possibilities.

Nagera's clinical elaboration, in the first published case presentation (1963), is authoritative and representative of the succinct character of Profiles at the Hampstead Clinic. The relative scantness, however, of his published clinical material in the body of a conventional Profile is misleading because there is no indication of the wealth of data available to the diagnostician. It may be helpful to note the convention and practice at Hampstead, viz., that extended data derived from diagnostic interviews of parent and child, projective and psychometric reports, school reports, etc., are used as the explicit base for the skeletal "profile." Since all research staff review precirculated diagnostic data in their entirety, the Profile itself can then be kept succinct and dispense with extensive documentations.

In settings other than Hampstead, and particularly for research publication, the scantness of data in the body of the Profile (i.e., presented *without* extended documentation) poses a problem of credibility. The need to extend the internal documentation of the Profile, i.e., in other settings, had been anticipated by the principal investigators.[2] The present extended paper is somewhat of an experiment as to the degree of documentation necessary to insure the adequacy of diagnostic credibility. The wealth of data in the case that follows is somewhat unusual, i.e., for a first Profile of a child. While it draws on two months of twice weekly treatment, it still remains evident that a considerable amount of relevant data is lacking—and in fact may be unobtainable without the depth provided by analytic treatment.

This broaches the additional research value of the Profile in the area of diagnosis and systematic investigations of the etiology of psychopathology, related defense organization, etc. As Nagera (1963) has noted, such research in London has included the diagnostic *reassessment* of a child during or on completion of analytic treatment. The comparisons of second and third Profiles of the same child, over varying periods of time, provide for increasing accuracy and corrections

[2] I am particularly indebted to Dr. H. Nagera (London), one of Hampstead Clinic's principal investigators, for his many helpful suggestions on the first draft of this paper and for his comments on the historical development of Profile research.

Special thanks are also due to Dr. J. Waelder-Hall for the opportunity of presenting this paper at the postgraduate child analytic seminar (Baltimore Institute).

of diagnosis via the depth of data provided in the child's analysis. Heinicke (1965) has made use of the Profile to research questions of effectiveness of treatment, etc. In the present assessment, two considerations led to the use of the Profile: (1) the great complexities of differential diagnosis in a latency age boy with both manifest neurological and psychopathognomonic symptomatology, and (2) the potentialities for research, i.e., if the child concerned should enter analytic treatment.

Gottschalk (1956) noted a particular diagnostic difficulty where in "certain types of paroxysmal activity, variously called 'psychic equivalent seizures,' 'affective epilepsy' . . . and so forth, it may become impossible to differentiate between epileptic experiences (and behavior) and nonepileptic experiences (and behavior). This is especially likely to be so when the presumed seizure activity involves complicated and highly integrated patterns of behavior and psychologic processes" (p. 352). The present Profile has attempted this type of differentiating assessment; it also led to the child's start in analytic treatment. The research value of the Profile necessitates second and third (if possible) reassessments. The publication of such extended documented material poses two problems: one expository; and the second, that of protection of the patient's anonymity. These considerations have led to some essential nonclinical distortions, which, hopefully, will not unduly complicate the reporting of future diagnostic reassessments of this case.

Diagnostic Profile

Ian F.

Age: 11 years 6 months (at start of treatment)

Sources of Information:

Psychiatric interview, Dr. A., Date: Current
Social history, Miss B., Date: Current
School history, Miss B., Telephone report, Date: Current
Intelligence test reports, Dr. C., Date: Current
Dr. D., Date: 5 years earlier
Neurological notes, Dr. E., Consultation records covering two years.
Psychotherapeutic treatment notes and interviews with parents, author's records.

I. Reasons for Referral

Ian's parents have been concerned about his well-being since the age of eighteen months when he was hospitalized with a convulsive episode that lasted three hours. Subsequently, between the ages of four and five years, Ian's aggression and behavioral difficulties were sufficiently trying that he was referred for psychiatric evaluation. At age six and a half (following the death of a sister, Gwen) Ian had his first psychomotor seizure. While neurological examinations and EEGs were negative, the clinical picture was classically that of a petit mal attack and he was started on anticonvulsants. At about age nine, Ian developed facial and neck twitches or tics accompanied by nauseous stomach sensations. These were considered neurological corroboration of the diagnosis of psychomotor seizures, and Ian's anticonvulsant medication was subsequently experimentally modified and increased to date.

During the year preceding this referral, Ian's school grades dropped markedly. Moreover, he became increasingly provocative and aggressive with peers and negativistic and rebellious with his parents, particularly his mother. The neurologist concluded that such increase in aggression might have accompanied an increase in medication.

The crucial determinant of the parents' decision to seek psychotherapeutic help was this increase in Ian's negativism and aggression, accompanied by the mother's despair that she could no longer cope with her son. In addition, the parents also feared that Ian's emotional difficulties were ruining his academic opportunities in one of the city's best schools. The parents were intelligent and insightful in their conclusions that whatever the intrinsic, organic or neurological nature of the boy's difficulties, he needed psychotherapeutic treatment. They had become increasingly aware of their son's impairment and distortion of his "self image," particularly evident in his repeated, perhaps manipulative, "I can't help it, after all I'm sick in the head." It is also clear that the parents were concerned about the possibility that organic damage might be progressive and that it could lead to psychosis. A referring psychiatrist had added to the parents' concern by his suggestion that the seizures might be hysterical and that the mother might have the greater need for therapeutic treatment.

II. Description of the Child

Ian is a rather handsome and impressive boy who is tall and well built for his age. He has raven black hair, a dark complexion, and is the more striking for the unexpected blue of his eyes. Ian stands in slightly exaggerated erectness, as if in awareness that someone might be looking at him. His rather handsome appearance is marred by an expression that is often "suspicious" and perhaps sullen; yet Ian can also relax into a gracious and warm smile when secure. In his initial treatment interviews, Ian's tics were constantly evident. His efforts to disguise them were frequently more bizzare than the tics themselves, e.g., strange movements of the head, twisting or poking at his eyebrows, etc.

It is apparent that Ian shares his parents' attitudes toward dress and personal grooming. He has come to his sessions from school, usually dressed in well-pressed slacks, clean shirt, a Windsor knot in his tie, well-polished shoes, etc. At other times, when coming from home, his garb may be casual, but in such instances his sweaters and trousers are in excellent taste and quality, suggesting a familiarity with the best of men's shops. Ian is also impressive and immediately so, for his precocious and pleasantly direct attitude in relating to adults (e.g., schoolmasters, psychiatrists, his therapist, etc.). Ian seems to expect that he should know and should be held responsible for his behavior. In this he seems consciously to anticipate adult evaluation and criticism; his expectation of adverse judgment is evident in his guilt reactions and self-recriminations (e.g., in not studying, in misbehaving, etc.). One senses a measure of insincerity in the boy's confessions, as if he had discovered a technical means of circumventing adult punishment by pseudo self-castigation.

III. Family Background and Personal History

The father's family has enjoyed relative wealth, impeccable repute, and considerable status as owners of extended estates in the English midlands. Mr. F. recalls his parents as being infinitely gentle, kind, and mutually tolerant. His father in particular was considered by the family as *not* second in place to the angels. Mr. F.'s only brother seems of some significance to this history because of his indirect impact on Ian, of which more will be said later.

Mr. F. was graduated from Oxford before World War II, following which he worked a short time on the family's estates. Abandoning this position, apparently precipitously, he secured temporary employment at an Austrian ski lodge. Thereafter, Mr. F. returned to graduate school where he studied philosophy. During his graduate college years, Mr. F. met and married Ian's mother. The sequence of subsequent events is not clear, but it appears that Mr. F. also taught at Oxford, served in World War II as a lieutenant in Navy intelligence, and at some point began his work with a government ministry where his activities were secret to the family, and by inference were exciting and dangerous. Mr. F.'s past and present work schedule has been predictable only for its irregularity; i.e., the family expects that he will be called away from home at night or for days on end. His present position has permitted a greater degree of stability.

Mr. F.'s appearance is distinguished, not least by his 6′4″ height and the consonance of his excellent physical proportions. He has handsome, though somewhat "pretty" features, set off by a shock of hair as black as his son's. In manner, the father appears reserved but quietly interested and alert. He is an intellectually insightful person who has long suffered from migraines and more recently from an acute depressive episode. On this occasion, approximately two years preceding this referral, Mr. F. entered psychotherapy which both he and his wife agree was of considerable help to him. From his therapy, Mr. F. notes that he dramatically identified with his own father who has always considerably influenced his life. As a result Mr. F. feels he has led an "as if" existence in which he "played at being in school," "played at marriage," "played at having an occupation," etc. He has agreed with his wife's accusations that he is and always has been far too passive. Mr. F. also noted that he felt he was different from others in his own incapacity to love with affection and intensity. He has always fought clear of emotions of any sort, e.g., consciously exercising self-controls even when viewing an emotional film or play. Mr. F. states that in years past he has had only two alternatives in coping with his son: (1) by mimicking his own father's gentle, superior, and benevolent attitudes; or (2) by treating his son as another adult. Mr. F. felt that his own therapy left him somewhat freer in his relationship with his son, in permitting greater expression of both fondness for Ian but also of legitimate annoyances and grievances.

Since Mrs. F. is most volatile and explosive, Mr. F. has been motivated over the years to intervene intellectually between mother and son, trying to mitigate the mother's apparent severity and discipline. Because of his own emotional isolation, Mr. F. could rarely give Ian much affection and had hoped that his wife, on Mr. F.'s urging, could recompense the boy in this way.

The father's depressive episode may relate to the death of his own father at that time. The paternal grandmother is still alive and family correspondence seems regular. There is no known family history of psychopathology or neurological disorder. The paternal uncle warrants comment because Ian links his own intensity to the time when this man's wife melodramatically deserted. The aunt absconded with her two sons, secretly taking them to France by airplane without warning either the children or her husband of her intent. She is castigated in the family as an evil woman who deserted for the only and express purpose of "catching a millionaire" (which she did). The elder son of that marriage, Ian's cousin, developed a stutter at that time; Ian notes feelings of murderous rage whenever he is reminded of his aunt by stutterers whom he hears today.

The father's contribution to Ian's misbehavior should be illustrated. During Mr. F.'s momentary absence, Ian burned pages of a school book in the family study in front of his mother (who had been reading there). When she intervened with both anger and anxiety, Ian wrestled with his mother, threw her to the floor, and when she just lay there he snarled, "Well! Have you given up on me again?" When the mother allowed herself tears (for the second time in her life in front of Ian), the boy contemptuously kicked her where she lay and walked out of the room. Mrs. F. was furious, outraged, and frightened. After her husband's return, she waited until her temper was under control and then told him of the event. The father was very angry and ordered Ian to his room where Mr. F. then remained to talk with the boy. Thereafter the father returned to Mrs. F., full of admiration for Ian's "keen insight." Ian had told his father he felt apologetic, yet he knew he would do it again (this was insight!). Ian was concerned about his mother's forgiveness, and the father told Ian that when Christ was asked how many times He would forgive, He replied not only forty times over, but as much more again if necessary. Mrs. F. wanted understanding and protection for herself, not a

comparison with or a fate similar to that of Christ. But she listened to her husband's unimpeachable Christianity and was eventually won over to the view that it was her responsibility to go to her troubled son and both forgive and kiss him so that he could sleep untroubled that night. Such incidents suggest a mutually unconscious collusion of father and son in which Ian perpetuates some of the aggression that the father denies in himself.

The mother's background sounds as explosive as the father's seems serene. The maternal grandmother in particular is eternally present, both in fact and in fantasy. She is described as a controlling, insidiously devouring woman who takes and holds everything she can. There is one maternal uncle, a source of continuing shame and humiliation. He is described by Ian's mother as a "professional psychopath," a drunkard, drug addict, a troublemaker, etc. He reputedly never "escaped" mother and the latter nominally continues to pursue, and in reality occasionally secures, the uncle's temporary psychiatric institutionalization. Mrs. F.'s aversion to (and fear of) psychiatry is identified with her experience with one of her brother's psychiatrists. Mrs. F.'s protestations that she had nothing to do with her brother's illness are sufficiently excessive to be suspect. One is immediately impressed with some sense of unconscious guilt as well as with her concern for this brother. The uncle's importance to Ian is of long standing, both because of the boy's incipient fear that he may have inherited some genetic defect and secondarily because of the mother's invidious and continued comparisons. She has harassed Ian over the years, telling him that he would be just as incompetent, incapable, or in need of institutional care, i.e., if Ian did not do as mother instructed. The mother is somewhat abashed in such self-reporting, but it is abundantly clear that she has felt that such "shock tactics" would be one of the only real ways of deterring her son from misbehavior. She does not recognize the fact that such comparisons serve only to frighten Ian and provide him with rationalizations.

It is known that the maternal grandmother lived in London when Ian was a toddler and that she occasionally cared for him then. Later she lived in the family's home for several years where, from Mrs. F.'s point of view, the grandmother was a constant source of chaos in the family. It is of interest to note that the increase in Ian's hostility and aggression at home coincided with the mother's insistence that the

grandmother move and find residence elsewhere. Ian indicates that he likes his grandmother very much, but separately notes to his mother that he needs help to protect himself from her excessive needs for hugs and kisses.

Mrs. F. is very tall, and is as attractive and equivalently well proportioned as her husband. She is invariably smartly dressed, well groomed, and her appearance is strikingly handsome, though not "feminine." Mrs. F. describes herself with nominal amusement as emotional, explosive, and strong-willed. (Her family and Ian's therapist would rather agree.) She also describes herself as most loving and interested in her husband and son, implying by this an ambivalent, erotic intensity. She feels that she is unsure of her maternal capacities and is consequently manipulable by innuendoes that might touch on her adequacy in this area, where she feels sensitive and guilty. Mrs. F. also feels that her husband is much more intelligent than she is and that she should follow his advice even when she is emotionally in profound disagreement. She bitterly resents her husband's "inability to be active and masculine," particularly in family matters where discipline or control of Ian has been important (from this statement one can draw a clear inference about their sexual relationship). Whatever difficulties may exist between the parents, they leave the impression of a fundamental and mutual respect, with an apparent reciprocity in their individual psychopathology which binds rather than divides them.

Sexuality was openly and excessively discussed in the house, in the "liberal and progressive" mood of the times. There have been, for example, detailed discussions of the approaches for intercourse in the matings of Ian's white rats. His surviving sister, Fiona, discusses her beaus' sensual overtures to her with the mother, but in Ian's presence. The mother has confronted Ian on the question of whether he masturbates, etc. The father has occasionally showered with his son, and Ian has felt free to walk into the bathroom of the parents, regardless of whether his mother or his father is there. This may be the more important since the parents have noted Ian's precocious move into puberty, evident in the boy's pubic hair and genitals. The father has insisted, as earlier noted, that the mother give more physical, intimate loving to the boy than she would prefer. She has accommodated in such matters, nominally only under duress.

The violence and intensity of feelings in the home, particularly between mother and son, will be noted elsewhere. The mother's temper, as well as Ian's, has precipitated innumerable quarrels over everything in the gamut of possible mother-child difficulties. While verbal discipline is common, isolation is more so. Physical discipline has included forcibly washing Ian's mouth out with soap, hitting him on the head with a broom handle, hitting him in the face, etc. This picture of violence within the family is deceptive, however. The violence is more impulsive than studied. Outside the home, the mother presents a most poised, socially presentable, and smart appearance. She is indeed an attractive person who seems to enjoy meeting others, going to teas, taking art lessons, etc. In other than family matters, the mother's poise and keen interest, her slightly caustic humor, are undoubtedly social assets that make her a well-accepted guest and friend.

Siblings: The F.'s first daughter, Fiona, is nine years Ian's senior. During her college years, she worked in biological and psychological sciences and seems to have a spurious knowledge of Ian's early neurological difficulties. Fiona is presently professionally employed and lives semi-independently in the family's house. Fiona's influence on her parents seems to be considerable; e.g., she apparently gives psychological direction or instruction to her parents. Little is known of her significance to Ian's early years or to his present life. So far as is known, Fiona has suffered from no psychological or neurological disorder.

The second child born to the family was another daughter, Gwen. When Gwen was eighteen months old, Mr. F. was assigned to Greece and the family moved to Athens. Shortly after their arrival there, Gwen suffered from encephalitis and was hospitalized with a convulsive seizure. Her subsequent slow development resulted in extended neurological examinations. Gwen had suffered brain damage and was left permanently mentally retarded. By the time of Mrs. F.'s next pregnancy (with Ian), Gwen was sent to an institution (the family having returned to London). The sister did not return home again, and Ian knew of her only as his sick sister who had to live in an institution because she was "sick in the head." Only at Gwen's death, when Ian was six years ten months of age, did he ever see her, i.e., when she was returned home for her funeral. Ian was described as

having been most upset, sorrowful, feeling tricked by his parents that he had not had the opportunity of seeing his sister in life (when in fact she had not been far from home). It should be further noted that Gwen had always been openly considered the mother's most loved and special child, though physically absent. Whatever ambivalence the mother must have felt for this damaged daughter, any rejection or disavowal seemed encapsulated by an overcathexis and restitutive undoing.

Friends: Parents, schoolteachers, and Ian agree that he has no intimate friends, yet that he has reasonably good peripheral relationships. There is apparently one boy slightly younger and much smaller than Ian whom he likes best. Little is known of their common interests or activities. At school, Ian is characteristically shy, reserved, indeed embarrassed if asked procedural questions by his teachers. Yet Ian is not rejected or teased for his shyness, though the mother reports considerable fighting with school peers during the previous year. The teacher does not confirm this, but rather thinks the parents have preconceived feelings and err in oversimplifying Ian's difficulties. Ian indicates that his size and athletic skills make him a much-desired participant in team sports; e.g., Ian is one of two boys who have been given special consent to play with the older ones in the school's regular competitive football matches. Ian's success at team sports is not matched by any direct friendships away from the structured and supervised team companionship. His occasional visits to the homes of acquaintances brought requests that he be permitted to stay overnight. Ian has never been successful in this because of his sleep disturbance (not a referral symptom); Ian becomes extremely unhappy and anxious because he cannot fall asleep away from home. Few boys call on Ian and still fewer ask him back for a second time.

Personal history: It is to be recalled that the parents decided to institutionalize Gwen when the mother became pregnant with Ian. Since she was the mother's favorite, it can be surmised that the pregnancy with Ian was not an unmixed blessing. Mrs. F. was troubled by indigestion and nausea; her delivery, however, was short and uncomplicated. Ian weighed seven pounds at birth and appeared to be a healthy and normal infant. He was described as a fussy baby in that he spat up considerably, though he ate well. He was not breast-fed. Troubles with formula occurred between ten and twelve and a half

weeks; he had continual diarrhea, which stopped with a changeover to skim milk. Bottle feedings were gradually replaced with a cup at age six months. Nothing is recalled as to his teething. There are no feeding disturbances, and there were no indications of maternal discomfort in Mrs. F.'s indirect allusions to orality, e.g., that the boy continued sucking his thumb until the age of two.

It is not without significance to Ian's oral needs, however, that the mother reported that Ian had difficulties which she described as related to sleep. Ian was left to "scream himself blue with rage." When, at the suggestion of others, Ian was brought down with the other children or adults and held, the mother reports (without insight) how surprisingly pleasant the child could then be. One may conjecture here as to the mother's early attitudes and fears regarding her infant son: she described him not as having been unhappy, but as having been "in a rage." It is quite clear, by inference, that the mother describes herself as unresponsive to her son's earliest infantile needs, and as expecting her son to be hostile and aggressive.

Ian is further described as having been a very active and determined infant and toddler, with early developmental achievements, e.g., walking at nine months and walking independently on the stairs by fifteen months. By age eighteen months, the boy was already memorizing and reciting nursery rhymes. The mother recalls with curiosity and surprise her own failure to capitalize on Ian's obvious intellectual precocity as a means of preparing him for the dramatic changes that then occurred in his life at that age.

At age eighteen months, Ian was left for a week with his maternal grandmother while the parents packed and made their farewells in preparation for yet another assignment in Greece. Ian rejoined his parents when they boarded ship in a milieu that was anything but "home," a situation which must have been fraught with all the additional tensions occasioned by the confusions aboard ship and the proprioceptive discomforts induced by a sea voyage. The parents found Ian inseparable, crying, and screaming if they tried to leave him alone, e.g., for dinner. Moreover, he would not nap and refused to sleep away from the parents at night. It is not clear whether the parents attempted to use phenobarbital at this time, as they did later. By the end of the voyage, separation anxiety had not abated and sleep had become a chronic problem, with Ian keeping the par-

ents up progressively later until two, three, or four o'clock in the morning.

In Athens, housing was difficult and the father's assignment took him away almost immediately. At their hotel, Ian gorged on food and finally and most pleasantly (to the parents) went to sleep. This left the parents with the impression that they could have one quiet meal together before the father left. Leaving a "do not disturb" sign on the door, the parents left the sleeping infant and dined at leisure. On their return, they found several frightened and very worried maids in the hall outside the door from which came the sound of Ian's voice screaming in panic. The maids, who feared to trespass, reported that the screaming had continued for some thirty to forty minutes. The mother recalled that when she entered the room it seemed impossible to her that one small child could have vomited so much. She felt intuitively that this situation was all too much, horrifically, like the time years before when her daughter had fallen ill (also at age eighteen months and also in the same city). The mother rushed Ian to the hospital. En route, Ian began to have a seizure that continued for three hours. The mother indicates that the convulsions were not controlled by medication and that her son was kept on the critical list in the hospital for the next two days. The hospital investigation of the convulsion indicated that the boy had no fever; neurological examinations and EEG were also negative. The mother's account is not clear, but it appears that following discharge Ian was returned to the hospital for outpatient examinations on at least two occasions. Attempts were made to use phenobarbital to facilitate repeated EEGs, and these precipitated acute panic reactions ("he was given enough to knock out a horse and it didn't faze him"). Attempts to examine Ian were apparently traumatic to both mother and child. Yet Mrs. F. later indicated to Ian's neurologist that the boy was kept on phenobarbital until the following year. There are no known sequelae to this episode.

While still in Athens, before the age of three, Ian was hospitalized for a tonsillectomy. However real or distorted, Ian recalls this as having been done under local anesthesia and insists that he recalls the surgeon dropping his tonsils in a wastebasket while his mother left the room in anxiety. It is of significance that Ian developed a devouring interest in dinosaurs, a thorough knowledge of their classi-

fication, and a preoccupation with them that was so intense as to concern his later nursery school teachers. It should also be noted that Ian had kept a "transitional object" throughout these years. It was abandoned in Greece, when his mother refused to take his "filthy blanket" back to London. The family returned there when Ian was three (during treatment it was learned that Ian still, episodically, demands his mother's silk scarf as a precondition to sleep). The return voyage to London was also problematic and difficult, with abortive attempts to quiet Ian's anxiety and excitation with phenobarbital. Little more is known of the boy's next year, during which time the family resettled in London.

The mother recalls little of Ian's habit and toilet training. She suggests that she was less demanding of him than she was of his sisters, and that he "may have been a bit delayed" in bowel control, becoming clean between the ages of eighteen and twenty-four months. Given the "normal negativism" and independence of this phase of development, and given the mother's present, demonstrable rage reaction to Ian for even looking disagreeable or in disagreement with her, one can only surmise that the mother's memory of toilet training has been expurgated. Ian, at this late date, remembers surprisingly more than is typical. At age four to five years, he reports that he was frequently constipated and afraid of letting go. On one particular occasion his mother insisted on giving him two tablespoons of castor oil. Ian lost his control completely and felt terribly ashamed. He has since concluded that his early constipation must have derived from his fear, viz., that if he ever relaxed, he would lose control and all his feces or insides would come out. He also recalls and describes with precision his mother's using enemas on him. (The mother separately volunteered that she did not think she had ever given the boy an enema. One may question whether this is the mother's repression, or whether there are anal, sexualized fantasies of the child involved here.)

At about age five, Ian was physically abused by an older boy in his neighborhood, who repeatedly picked on him. The parents were concerned that Ian had provoked such attacks (and there is an inference of sexual assault suggested by Ian in his psychiatric interview; i.e., Ian described masturbation as that which little boys are forced to do by bigger, older ones who take them off alone). Details are

limited, but it appears that from the age of five, Ian persistently attacked his own peers. There are also reports that at the same age he was in various types of trouble with his parents and that he may have been a firesetter as well.

As a consequence, Ian was referred for psychiatric diagnostic evaluation at five and a half years. He was tested by a Dr. D., who administered both projective and psychometric tests. The latter indicated a high intellectual potential, with a Binet (L) I.Q. of 136. Ian was grossly fearful of aggressive impulses and dangers. His castration anxiety was exceptionally open, with the boy holding his hands over his penis during much of the examination, yet somehow finding it possible both to unzip his trousers and to unbuckle them so that he had to ask for help from the examining psychologist at the end of the session (counterphobic?). Mrs. F. remembers some of Ian's interview, particularly his "three wishes." Ian had wanted a new mother, a toilet tank, and something else the mother could not recall. Ian was given the toilet tank for his backyard, but not psychotherapy. The installation of the toilet tank is recalled by both mother and Ian as giving rise to considerable amusement and pleasure, with the neighborhood children as frequent visitors who came to play with it and Ian. In line with this interest, Ian also became a precocious reader and owned an encyclopedia set of his own. His keenest interest was in the study of waterworks, internal plumbing, etc. (such interest has continued to date, but at a vastly more sophisticated level; Ian now studies "water hydraulics").

As previously noted, Ian's sister Gwen died when he was six years ten months of age. He saw her for the first and last time at the funeral. Some two weeks later, as Mrs. F. recalls, she was sitting at dinner and asking Ian his multiplication homework—when he had his first psychomotor seizure. The mother gives a very graphic description of her son's behavior, a classical neurological picture of a petit mal seizure. During the following two years, Ian apparently had six or seven similar seizures. The neurological examinations that followed included some four or five EEG's, all negative with the exception of one that seemed a bit "suspicious." Increases and changes in medication were followed by initial abatement in the seizures, which invariably returned shortly afterward. Medication was progressively increased over many months with dosages of Meberal, and eventual

substitution of this by Mysoline, always accompanied with dosages of Dilantin. Ian's present dosage is 1000 mg. Mysoline, plus 200 mg. Dilantin taken thrice daily.

With the change in medication there may have been a modification of seizures or their manifestation, e.g., the first appearance of his tics. It is clear that Ian began to develop more extended difficulties with his sleeping during this time and that he became more explosive and more provocatively difficult with his parents. The neurologist expressed concern that medication might be responsible for the explosiveness, but could see no relationship to the sleep disorder. It should also be noted that Ian was undergoing orthodontic treatment during these times and there was concern that massive doses of Dilantin might adversely affect his gums. Ian also suffered from a diaphragmatic hernia, diagnosed about age nine and a half, and surgical correction remained a continued threat. Eventually Ian was hospitalized at age ten and the hernia was corrected under a general anesthetic, but without surgery (via oral, esophagal probe).

The family is Anglican and Ian is a very religious child, which he partly exploits in asking for parental (if not Divine) absolution. At the mother's persuasion, Ian had continued a childhood practice of sharing his confessions of the bad things he had done during the day, i.e., until age eleven. The parents had been concerned that Ian should not have to feel guilty. Ian seems to exploit his parents' sensitivity by using his "confessional" maneuver to manipulate his parents, knowing that if he "confesses" he will not be punished, i.e., directly. But it is also evident that the parents have been frustrated and angered by this behavior, and have punished the boy indirectly for different, otherwise acceptable behavior. Ian evidences the normal range of conventional moral values for a boy his age. At school and at others' homes, Ian's reaction formations seem well maintained; he appears honest, compliant to the interests and needs of others, cooperative, respectful of others, sympathetic, etc.

The dramatic difference in Ian's attitudes and regressive values is evident only at home. The aberrant nature of his misbehavior and particularly his open aggression impressed the parents as evidence of gross psychological disturbance. Detailed information of the mother's interactions, her seductive attitudes, and her provocations need to be assessed, however. To illustrate, Ian made a snide comment con-

cerning his sister and the mother involuntarily slapped his face. Hurt, humiliated, and angry, Ian ran up the stairs shouting choice and unkind things at his mother. At the top of the stairs, Ian paused to pick up his baseball, turned and gestured as if he would throw the ball at his mother. At this juncture, she smiled and sarcastically suggested that Ian throw it; and with this she turned her back and started to walk away. Ian, in fact, threw the ball and hit his mother. The pain was apparently considerable and the mother found herself in tears, something that she had never permitted herself in front of the boy. Ian was shocked and dismayed by his mother's behavior, begged her forgiveness, and was a model child for a short while thereafter. Whatever the mother's ambivalence to her son, whatever her seductions, the degree of Ian's provocations cannot be minimized: Ian is a constant tease, and a not-too-humorous, rather sadistic mimic.

With the increased behavioral difficulties at age ten, Ian's parents asked for a psychiatric re-evaluation. While psychotherapy was recommended, and the question was raised as to the mother's need for therapeutic help, the consulting psychiatrist did not have sufficient time free to accept Ian. Further modifications and increases in medication were made that summer on a neurological basis, with Ian's seizures again diminishing, particularly at a time when he was separated from his parents and spending his vacation on one of the family's estates. While his seizures abated, Ian reportedly threatened a kindly adult with violence and was involved in many provocative disputes with an older boy. These incidents seemed important since the inference was that Ian provoked in such a manner that it was he who would be punished. Ian ran away from the family estate, hiking and hitchhiking some 30 to 40 miles to rejoin his parents. The seizures re-emerged at home and the last psychiatric referral was made to Dr. A., and then to me.

Ian was initially resistant to treatment, e.g., forgetting to leave school in time for his appointments, being "disturbed with school matters" and running away from school instead of coming to treatment, etc. During the first two weeks of therapy (he was seen twice), Ian acted out considerably; e.g., mutual, nude exhibitionism with a neighbor boy, smashing a window at home, threatening his father with a prized saber, etc. Treatment was then increased to two appointments per week; the immediate result was complete cessation of

acting out at home. Ian has since come to his treatment sessions with verve and enthusiasm. He has viewed his treatment as an introspective "detective story" in which he searches his experiences and memories for clues to the origins of his difficulties, for pieces of his own jigsaw puzzle. Ian has displaced some of his provocative teasing of his mother into his treatment sessions, where he enjoys and now openly delights in intellectual torture of his therapist. But Ian is also able to look at himself somewhat intellectually, lamenting his lack of friends, his humiliation in his sleep disorder, and considerably enjoying the ready acceptance he has found in his therapist. Treatment is of interest and acceptable, i.e., so long as this does not reach too far or come too close to Ian's most sensitive areas (e.g., feelings of humiliation, worries over toilet matters, questions of his sanity, etc.).

IV. Possible Significant Environmental Influences

Ian's neurologist, a most experienced specialist in childhood disorders, was unequivocal in his conclusions that this boy suffered from an organic convulsive disorder, petit mal in nature and idiopathic in origin. What had struck me, however, was the fact that Ian had never been seen by the neurologist during a seizure and that the clinical description of such seizures had been largely provided by the mother. What is also suspected, but not clear, is the degree of Ian's suggestibility, his readiness or potentiality for physical expression of maternal suggestion of his illness.

It may well be that Ian's seizure condition derives solely from an organic dysfunction. But Freud's comments seem of particular interest in the diagnostic assessment, viz., that it is "quite right to distinguish between an organic and an 'affective' epilepsy. The practical significance of this is that a person who suffers from the first kind has a disease of the brain, while a person who suffers from the second kind is a neurotic. In the first case his mental life is subjected to an alien disturbance from without, in the second case the disturbance is an expression of his mental life itself" (1928, p. 181).

The neurological evaluation and diagnosis cannot be improved on. Yet it would seem desirable to consider Ian's developmental history with a view to assessing alternative psychogenic contributions to his seizures. Whether organic or psychogenic (or possibly a combination of these), there are a number of "significant environmental

influences" (1) which may have lowered a neurological-psychological seizure threshold, or (2) which have predisposed the ego organization toward hysterical discharge processes and interrelated psychopathological defense organization. Whatever theoretical orientation might be emphasized, the same basic environmental influences seem relevant:

1. The mother's early (and continuing) incapacity to respond to her son's needs as an infant, e.g., letting him scream "until blue in the face." The mother's projection of her own aggressive expectations seems paralleled, in this respect, by her intolerance of passivity and her need to provoke aggressive responses in her son.

2. Separation from the parents at age eighteen months for one week, followed by the immediate loss of the home environment, and consequent disequilibrium aboard ship (separation anxiety seems specific and related to sleep disturbances).

3. Accumulative fatigue and anxiety during the ship's voyage; plus excitation due to the ship voyage, sharing of parents' bedroom, change of language, etc.

4. Acute anxiety attack in hotel, with screaming, vomiting, etc., in absence of parents. Possible cyanotic asphyxia from screaming and consequent aspiration of vomitus (?) with consequent convulsion.

5. Hospitalization of Ian, with further separation, acute anxiety of both child and mother (in the absence of the father).

6. Attempts at both massive medication with phenobarbital and electroencephalographic examination; consequent manic-hyperactive response.

7. Tonsillectomy at age two and a half, same hospital (?), local anesthesia (?).

8. Further exacerbation of separation fears with change in home, environment, ship voyage, return to London; acute anxiety reactions and panic; attempts to quiet him with phenobarbital on board ship; age three.

9. Impact of mysterious, exciting, and dangerous implications of father's occupation and nighttime absences.

10. Parental attitudes are particularly suspect. There is an impression that they feared Ian's convulsion in infancy might have left him damaged, like his sister. Parental overindulgence at present suggests possible overindulgence in infancy so that age-appropriate

expectations were inconsistently demanded. The mother also expected her son to be similar to her "professionally psychopathic" brother and has long viewed Ian as potentially defective, e.g., in his lack of control of rages. One suspects that the mother compensated for her ambivalent aggression by inconsistent, restitutive overindulgence. This is consonant with the tentative view of her needs for anal-sadistic battles, evident in her own comments that she cannot "keep her hands off of her son, either in anger or affection."

11. The physical attacks on Ian at age four or five appear to be symptomatic (because of provocations) rather than precipitating causal experiences. Yet it is possible that the child experienced a sadistic or sexual attack. Ian's account of anal assault by the mother during his phases of constipation could be true or might represent fantasies relating to anal-sadistic sexual wishes.

12. The sister Gwen existed as a phantom, an ideal, best-loved child who was absent *and* "sick in the head." The potentialities for identification with the sick or dead sister are facilitated by the actual facts, and by the family folklore of the remarkable coincidence in which Ian suffered his infant convulsion at the same age and the same place as the dead Gwen. It hardly seems fortuitous that Ian's first seizure occurred within two weeks of his sister's death and his first and only view of her.

13. Hospital and medical examinations, electroencephalographic investigations, and the various pharmaceutical medications have all been environmental interventions and probable stresses. The significant ages would appear to be eighteen months, three years, six and a half years, and rather continuously since then. Ian seems to have handled his later neurological and medical examinations comfortably, but it is evident from his treatment that he fears that he is "brain damaged" and potentially insane, a boy whom the best doctors and the best medications have been unable to cure.

14. The date of diagnosis of Ian's diaphragmatic hernia is not clear. One wonders if this is coincidental with the increase in the boy's seizures two years ago.

15. Equally obscure are the inferences that Ian's paternal grandfather died two years ago, that the father suffered a concomitant and prolonged depression, and that the maternal grandmother was rejected from the family household.

V. Assessment of Development

A. *Drive Development*

1. *Libido*

(a) *With regard to phase development*

There seems no question that Ian has reached the phallic stage of psychosexual development and has made tenuous advances into latency. Phenomenologically, the latter is evident in Ian's relatively adequate academic competence, his active and interested participation and skill in particular group sports, his capacity to relate (under structured circumstances) and take at least minimal pleasure in some age-adequate activities with peers and adults other than his parents.

Such progression, however, is not secure and Ian's capabilities remain partly dependent on his being reassured via the supervision of adults. Ian's schoolwork also breaks down, sometimes completely, when the mother insists on supervising his homework. He is more successful when he isolates his schoolwork and arranges to remain in school in the afternoons to continue studies under the more benign supervision of a teacher.

The tenuousness of Ian's freedom from oedipal, sexual and aggressive drives is clear, even to the mother who notes her son's unusual interest in her and feels his provocations have an odd aura of sensual sadism. One clearly sees the existence of libidinal fixations in the anal phase in Ian's beginning references to toilet problems, his difficulties over enemas and constipation, and more particularly in the ease of regression in which he provokes and fights with his mother (as a love battle).

The evidence of oral fixations is not clear. The history notes an early yet transient feeding difficulty. More suspect are the reports that the child was left to scream in times of need. Ian presently attributes his having orthodonture treatment to self-damage caused by prolonged thumb sucking, i.e., until age two years. There is a long history of oral, medical interventions and it should also be recalled that the vomiting at age eighteen months preceded the first convulsion. If there is a hysterical contribution to Ian's seizures, then the boy's oral and labial tics and mouthings, plus his nauseous stomach feelings, should be questioned as derivatives of oral fixations. It is equally clear that the more dramatic oral traumata occurred

during or after the anal phase of development. Whether such oral assaults were experienced or understood as a consequence of anal retribution (upwardly displaced) or whether they may have reinforced a more primitive oral fixation is anything but clear.

Ian's characterological and defense organization, however, is predominantly anal. His history of continuing interest in waterworks, toilets, etc., indicates the existence of excremental sexual fantasies, and permits the inference of fixation, and perhaps regression, from phallic to anal expression of libidinal phase dominance.

(b) *With regard to libido distribution*

(i) *Cathexis of self:* While Ian is not hypochondriacal, his seizure condition has greatly contributed to an intense self cathexis, both of his body and his psychological self-awareness, self-judgment, etc. Despite this high cathexis of the self, it does not seem positive or pleasurable. He makes high demands of himself, e.g., that he should be well dressed, scholastically superior, etc., yet he obtains little gratification from his successes. On the contrary, Ian gives the impression not only that he feels he is organically defective or damaged, but also that his standards (introjects) are so perfectionistic that whatever the adequacy of his real-life performance, it is never quite good enough to leave him pleased or secure with himself.

(ii) *Cathexis of objects:* Ian's cathexis of his objects is relatively normal, i.e., it shows no evidence of borderline or psychotic processes. There is a neurotic, psychopathological unevenness of cathexis, however, since Ian views his objects as potentially dangerous or threatening to him. There is an intense ambivalent cathexis of objects, particularly during his regressions, which are markedly reminiscent of the toddler stage of development; e.g., he expects his parents to accept his violent aggression not only without objection, but with love and forgiveness.

2. *Aggression*

(a) *Quantity of aggressive expression*

Ian appears to have a relatively normal endowment of aggressive drives, but his history suggests an abnormal degree of reactive aggression from infancy onward. This could relate to the mother's ambivalence and need to stimulate aggressive, masculine responses

(which she finds so lacking in her husband). Both the developmental and the current history are replete with incidents in which the mother helps to perpetuate ongoing, sadomasochistic battles over even the most incidental of matters. Ian's experiences at age four or five when he attacked his peers has the sound of an abreactive, passive-into-active defense in which he enacted on others what he had experienced himself (the attacks on him by the older boy). Yet this behavior is also described by the parents as having been provocative. In this sense, Ian's very early behavior fits a general pattern of sadomasochistic provocations which may have continued from infancy onward.

While Ian's aggressive outbursts have the appearance of quantitative abnormality, one might better view these outbursts in terms of imbalance in that aggressive fury is defended against in most social situations, yet is afforded too frequent, too prolonged expression at home (where the father remains Ian's apologist). Ian notes, for example, that by the age of five he was quite prepared to set fires in ashtrays, throw over chairs, throw knives on the floor, all as manipulations to insure that his mother would return home from a cocktail party when he was in a fury and wanted her.

At noted earlier, in structured situations such as football games, his aggression is effectively directed. It is only at home that Ian has "let himself go" and demonstrated his negativistic fury in fierce and vulgar arguments, in physical battles with his mother, etc. His relationships outside of the home have remained relatively free of such outbursts, although during the previous summer there were indications that Ian's fears and aggression might be carried over into other areas of his life as well.

(b) *Quality of aggressive expression*

Ian mimics his parents' attitudes when he speaks of his "violent feelings." While using a vocabulary of violence, he speaks with a bland and sometimes humorous affect. It is not clear whether Ian parrots and makes jokes of his parents' expectations that he should feel terribly upset and aggressive over incidents which might otherwise seem trivial in everyday life. At other times, he speaks almost melodramatically of his evil deeds and attacks (e.g., of running his father through with a saber) when in fact the incident was more one

of Ian's fantasy and *not* one of action. While such behavior has the appearance of a "breakthrough," as if it were psychotic, it gave the clinical impression of a contrived dramatization and a perverse reversal of values, which could be related to parental acting out. In illustration, the father tends to see all of Ian's misbehavior as expected and forgiven from its inception, even his breaking of windows, throwing the mother to the floor, etc. The mother, in dramatic contrast, seems to see any small indication of teasing or refusal as tantamount to rebellion against established authority. Ian's *modes* of expression of aggression are as unbalanced as the quantitative expression. In fact, he has been unexpectedly violent over relatively trivial matters. On the other hand, he has accepted inappropriate discipline of himself as being logical and desirable. One is left with the confused impression that, for this boy, aggression in any form may at one time be devastatingly horrible and at another time have little significance because it will be excused no matter how inappropriate.

(c) *Direction of aggressive expressions*

There is lack of aggressive reaction toward persons who have in reality actually deprived, hurt, or demeaned Ian. He rarely permits himself to express openly or appropriately a legitimate grievance or annoyance. Yet he berates himself at such times for his horrible tempers and anger, which in fact have not been expressed. It is not surprising to find that Ian is devoutly religious and prays to God for help with his rages (and also melodramatically and manipulatively exhibits his religiosity to his parents). It is clear that Ian provokes people in such a way that they are bound to direct aggression toward him. His excitement, evident in treatment, suggests a masochistic overdetermination. When Ian does express aggression directly, it is usually inappropriate, disproportionate in its intensity, and more often directed toward his mother (as a scapegoat?).

Freud (1928) believed that hysterical convulsive disorders involved a massive turning of aggression against the self. Bartemeier (1932, 1943), discussing and extending Freud's views on the hysterical features of convulsive disorders, noted that the superego may use an existing tendency to seizures as a means of directing aggression against the self. Ian's seizures could represent such a turning of

aggression against the self, but this cannot be documented at this time.

B. *Ego and Superego Development*

1. *Ego Apparatus*

Ian's ego apparatus (his endowment of physiological and sensory equipment facilitating ego functioning) seems to be intact. If his seizure condition has an organic basis, one would hypothesize transient and perhaps global impairments of the entire ego apparatus. Yet studies such as those of Peterson et al. (1950) suggest that patients with hysterical convulsive disorders have full recall under hypnosis for events occurring during the time of the seizure. Whatever the etiology of Ian's seizures, they do not seem to have affected his basic progression and relatively normal development.

2. *Ego Functions*

Ian has been tested on both the Stanford-Binet and the WISC, at ages five and eleven. In both instances, his performance was at the superior level. Until a year and a half ago, his school performance was most adequate in a competitive setting with high standards. The impairment of intellectual ego functions seems to be of psychoneurotic origin and his difficulties in this area seem to be affected especially by his mother's concerns.

Ego functions such as control of motility, integration and synthesis, may be impaired by Ian's seizure potential. It is noteworthy, however, that he has never injured himself physically during a seizure and (so far as is known) that he has never been observed having a seizure other than in the presence of his parents. (However, see also Section 4, Secondary Interference.)

3. *Defenses*

Ian's relative honesty, cleanliness, pity, and compassion, etc., are clearly and firmly established. One would consider them well-established reaction formations if it were not for the fact that Ian seems to derive little or no *pleasure* from the gratification of these opposite-drive tendencies. One may conjecture that Ian cannot tolerate or find pleasure in himself (excessive standards or extreme punitiveness of the superego?) or that the urgency of the unconscious aggression

is so demanding and unsublimated that he pays a constant, defensive price in keeping alien aggressive impulses in check.

Projection of aggression is in pathological evidence, with Ian misconstruing unstructured or ambiguous situations (or comments) as evidence of anger and potential rejection of him (e.g., by teachers, friends, therapist, etc.).

Ian "panics" when he is unable to sleep away from home; he fears that something will happen if everyone else in the house goes to sleep before him. He is afraid he might die from accumulative fatigue when he is unable to sleep; his environment seems alive with aggressive and hostile undercurrents. Treatment suggests that there is an excited malice in the boy's midnight interruptions of his parents' sleep, in his telephone calls asking them to bring him home when he is unable to sleep at a friend's house. While the behavioral characteristics of Ian's sleep disturbance support the mother's conviction that it originated at eighteen months (in connection with separation anxiety), Ian's fantasies that mothers kill fathers and abandon them (for millionaires) suggest that the sleep disturbance also incorporates a projection of the boy's own anger and death wishes toward his father. One should also consider that the mother may be explosively aggressive, that she may reinforce Ian's fears of an extremely aggressive world. Such factors provide Ian with a rationalization for the appropriateness and intensity of his own feelings, thereby masking both Ian's provocations and the indigenous base of his own projections. On the other hand, Ian's extrafamilial school milieu is quite benign; yet Ian carries his own internalized, defensive attitudes into his peer relationships, which are independent of the reality of his problems with his parents.

Denial of affect and *intellectualization* are two defenses that seem to be characteristic modes of Ian's coping with everyday matters. He rarely permits himself to experience age-adequate feelings in an appropriate manner. He functions as a rather "feelingless" young man who intellectualizes and reviews his behavior from a psychological distance. While Ian's use of defensive intellectualization has the appearance of a precocious adolescent reaction, it seems developmentally related to his parents' extensive intellectual expectations of their son; i.e., they treat him as if he were an adult. There are also indications of obsessive ruminations that possibly reinforce in-

trospective intellectualization, as a means of controlling drive activity.

Regression is another characteristic defense, which is particularly in evidence at home, under stress. In public, Ian functions rather well, e.g., at school or when adult friends are visiting his home. He successfully avoids and withdraws (with phobic characteristics of anxiety if he cannot avoid painful situations), and retreats physically to his home where he may then regress emotionally to anal-sadistic behavior. In this, he is petulant, demanding, torturing; and he expects complete acceptance from his parents no matter what he has done. Fearing even worse behavior, the parents have accepted, if not reinforced, such regressive and infantile behavior.

Identification with the aggressor is clear in Ian's mimicking and provoking of his mother, his therapist, etc. His behavior seems to have a degree of conscious purposefulness when he denigrates and cynically exploits or exhibits his parents' shortcomings by adopting inappropriate behavior which they have in fact exhibited to him. Ian's misbehavior is a parody of his mother's lack of control, and with it he mimics and cynically exploits her guilt.

Ian's earliest history also supports the view that aggressive identification may be syntonic (and not altogether defensive), e.g., as an effective mode of coercing his parents to give him care and attention. His ability to identify has been effectively used in learning by anticipatory trial actions.

Ian's defenses are not characteristic of his age, and the lack of joy or self-confidence suggests that sublimations are possible only to a limited degree. His defense organization does not seem adequate to the task of coping with excessive aggressive and sexual conflicts (partially influenced and exacerbated by provocations and seductions of the parents). The two characteristics of turning aggression against the self and identification with the aggressor may relate to a masochistic, sexual conflict, but this is obviously speculative.

4. *Secondary Interference with Ego Functions*

Ian's reality testing, e.g., of the benign or malignant nature of situations or people, is significantly impaired, and in this respect there is clear evidence of interference with ego functioning.

Ian's school performance was transiently impaired at about age

five, when he was said to have been obsessionally concerned with dinosaurs. Academic functioning, however, remained relatively free thereafter until about age ten, and since then it has varied considerably and dramatically. Cognitive functions, as demonstrable via psychometric tests, remain relatively free. Ian's intellectual capacities seem impaired predominantly via the mother's concern or interventions. Preliminary exploration of Ian's underlying fantasies (in treatment) suggests that full exploitation of intelligence is impaired by a fear of success and an inhibition of exhibitionism. Ian fantasies, for example, that he is a genius whose success could be so overwhelming that either he would devastate his competitors, or they would be so fantastically jealous, envious, and hostile that they would murder him for his success. Ian's fantasy life fits in with Sperling's theoretical formulations of petit mal in children. In discussing psychogenic headaches, petit mal and epilepsy, Sperling (1953) suggests that "*petit mal* is interpreted as an instant cutting off from functioning of those parts of the mind which serve the perception and execution of stimuli from within and without, because perception of certain stimuli would lead to an explosive reaction endangering the life of the patient and that of the people in the environment" (p. 252).

C. *Development of Total Personality (Lines of Development and Mastery of Tasks or Age-adequate Responses)*

1. *From Dependency to Emotional Self-Reliance and Adult Object Relationships*

Ian appears to be having a very difficult time consolidating himself in latency (Stage 6). There is much evidence of attempts to establish mutual and reciprocal relationships with a select group of boyfriends and responsive teachers. Such relationships are not secure and may break down when Ian meets with frustrations that are amenable to misconstruction, e.g., when an acquaintance fails to telephone, when there is a relevant criticism of schoolwork, etc.

Not unrelated is Ian's difficulty in maintaining his academic work, particularly when his mother tries to help him. The most dramatic disturbance of object relationships is Ian's incapacity to cope with his parents. The intensity of the battles between parents and child is sufficiently dramatic to obscure the more fundamental

fact that Ian has been unable to establish age-adequate and conflict-free relationships outside of the family.

While Ian has been described by his parents as a self-reliant, emotionally self-contained and independent boy, the developmental history documents other features as well. Separation anxiety, clinging, and inability to separate were manifest at eighteen months and thereafter. The use of a transitional object, "the filthy blanket," cannot be unrelated to Ian's present, though occasional, need for his mother's silk scarf as a prerequisite to going to sleep. Similarly, Ian's inability to sleep away from home, his fear of being the first to go to sleep, his self-isolation from peers, all reflect on his dependence.

2. *Toward Body Independence*

(a) *From suckling to rational eating:* Ian's earliest history is equivocal but suggestive of inconsistent oral gratifications and complications. Historically later oral traumas have been noted. Whatever battles may have evolved in the family's eating patterns or traditions, it appears that Ian's attitudes toward food and eating have now approximated those of the parents and are age-adequate. He seems free from notable food fads, battles over meals, and readily and appropriately can eat away from home, seemingly at any time or place. This may overstate the case, since Ian is also most egocentric and can hardly envision that he should eat at any time or place that he might dislike. In the selective, benign environments in which he is cared for, covert oral problems could readily be disguised. However, it appears that Ian has moved relatively completely into rational eating that is uncontaminated by psychological conflict.

(b) *From wetting and soiling to bladder and bowel control:* Ian became dry and clean at about age two. So far as is known, there have been no regressions (encopresis or enuresis) when he was ill, emotionally upset, and during or after seizures. His attitude toward cleanliness, neatness, etc., seems Spartan. It is not surprising to find Ian volunteering the information that it was appropriate for his mother to have washed his mouth with soap when he first used "dirty words." Whatever developmental battles may have occurred in the line toward independent bladder and bowel control, it is evident that these controls are both secure and age-adequate.

(c) *From irresponsibility to body management:* The history of Ian's precocious motor abilities and his aggressive, nominal independence are consistent with his present capacities. Ian seems completely responsible and fully capable of his own body management, including responsibility for intake of medications. If there is anything unusual, it is in the excessive independence rather than in the failure to take responsibility for body management.

(d) *From egocentricity to companionship:* When conditions are favorable, Ian seems to relate well and to accept the mutual needs and interests of other children. He is unable, however, to do this under stress, e.g., in groups lacking adult supervision, when visiting away from home, etc. It is clear that Ian relates to other children at least as temporary helpmates in sustained activities such as group sports and occasionally on an individual basis in play. Ian's treatment material suggests a yearning for peer relationships and a sorrow that he cannot maintain friendships. He is somewhat aware of the reactions of other children to his own joking provocations. It is also clear that he has a capacity to identify with other children as "objects in their own right," as persons whose feelings and wishes he would like to acknowledge and would like to respect. The parents' and Ian's reports suggest that he began a more secure step in his social relationships about a year and a half previously. This evidence indicates that Ian had reached Stage 4 on this line of development, however tentatively, and that his present inability to accept or reach out for companionship and friendship derives from a neurotic interference.

(e) *From the body to the toy and from play to work:* Assessments of this developmental line take into consideration the earliest cathexis of the infant's body, the extension of cathexis to the mother and to inanimate objects such as "transitional objects." Stage 3 describes the toddler who may cuddle and maltreat symbolic objects with a full range of expression of his ambivalence toward them. In Ian's case, one is impressed by the fact that his episodic regressions are to this stage of development. However, I hesitate to use the term "regression" because his developmental history clearly indicates that such behavior has persisted from early infancy onward. Ian's use of his mother's scarf, however, is not syntonic and gives rise to shame. This need does seem regressive and is consonant with developmental

fixations in a very early stage at which "transitional objects" are cathected as an extension of the mother.

Ian's toys, his hobbies, and his physical activities in sports are aggressive and phallic in nature and are used to express and work through transient fantasies. He has extensive sets of toy soldiers and battle equipment, and in his play with them he usually identifies with the Nazi and Russian armies, identifications which are consonant with other manifestations of his sadomasochistic and aggressive impulses (which are not adequately neutralized). His pleasure in and capacity for task completion and problem solution show a clear, however tenuous, move into Phase 5. As noted earlier, Ian is dissatisfied with his capacities to function adequately and is hypercritical of his performance. He leaves the impression that he is grossly insecure as to his capability in functioning, therefore turns to his objects for reassurance, and when this is lacking, regresses to earlier stages under stress.

Many of Ian's achievements seem based on counterphobic dynamics, e.g., his study of water hydraulics, the collection of sabers and guns, etc. He has obviously mastered the drive controls and achievements necessary for such activities, but the autonomy of such secondary ego functions is not well established and he seems to lack an adequate degree of neutralization and sublimation, both prerequisites for the ability to progress from play to work.

3. *Assessment of Correspondence between Developmental Lines*

There is a high degree of consistency in an overall evaluation of the different developmental lines. On the side of ego development, there is a uniform and marked precocity and early achievement beyond age-adequacy and expectations. But equally consistently, one finds Ian unable to make use of his excellent endowment and ego skills. He is not satisfied with himself; he shows an inadequate capacity to separate from his parents; a limited capacity to maintain age-adequate relationships with peers; and a marked restriction in the progression from play to work.

VI. Regression and Fixation Points

The early developmental history, though ambiguous, suggests that Ian received inconsistent care in relation to his early oral needs.

The history of oral traumas, dating back to eighteen months, continues through the latency period. Since the child's early years were symptom-free, the degree of orality implicit in Ian's psychomotor seizures may in fact have stemmed from retrospective trauma, or may otherwise reflect an upward displacement of anal and phallic fears of damage.

The mother's known attitudes to and intolerance of aggressive activity or "insolent disregard" of her wishes must be considered along with the fragmentary evidence of early fixations. It is particularly striking that the mother fails to remember her son's habit training when Ian so vividly recalls his extended troubles with constipation, laxatives, and enemas. It is clear that Ian was precociously active and aggressive, presumably before the advent of habit training. Given his particular assertiveness of independence, along with the normal negativism of the average toddler, one can only conjecture on difficulties of toilet and cleanliness training. Dominant defenses and character traits suggest anal fixations, which were perpetuated into phallic and (fragmentary) latency development. Both the neurologist and Ian's therapist have noticed the interesting and continuing fact that the boy's aggressive outbursts become more extensive and frequent when he is *less* subject to seizures. This permits the inference, as one possibility, that the psychomotor seizures are a regressive, primitive psychophysiological response which occurs when anal-sadistic behavior is checked. Whether Ian's symptomatic mouth movements, tics, and nauseous stomach feelings reflect early oral fixations or are merely a concomitant of primitive psychophysiological reactions is quite unclear.

The mother's comments on Ian's phallic development are largely negative; i.e., she does not remember exhibitionistic, protective attitudes; competitive play initiated by Ian with his father; genital masturbation, etc. Yet the psychological evaluation of Ian at five years six months is striking in its emphasis on the boy's phallic anxieties. At that time, the boy's projective materials were predominantly concerned with aggression and castration fears. Ian's concern for a toilet tank could reflect regressive anal preoccupations; or, if considered along with his extended interest in waterworks, it might be better understood as reflecting his concern about phallic potency. We know from the father that he asked, if not seduced, his wife to

indulge the boy in intimate and caressing body care. Ian's continuing sadomasochistic, highly exciting and sexualized aggression with his mother indicates an anal-sadistic manifestation of phallic drive development.

In the attempt to assess the question of regression, one should recall that the first psychomotor seizure occurred in the middle of Ian's sixth year, shortly after he saw his dead sister. It will be recalled that she was the mother's favorite child who was "sick in the head." I suspect that this trauma may have precipitated further regressive tendencies at the very time Ian was making peripheral and tenuous movements into latency.

VII. Dynamic and Structural Assessments (Conflicts)

A. *External Conflicts*

This section of the Profile is customarily used for much younger children, i.e., prior to the internalization of conflicts. Some of Ian's behavior is sufficiently bizarre or aberrant to indicate that only limited or inadequate introjections (in terms of superego formation) may exist. In view of the open and regressive conflicts within the family, some of Ian's reactions have the quality of external conflicts with the parents. From the parents' point of view, these are external conflicts because the boy is "psychopathic," without conscience.

B. *Internalized Conflicts*

Ian has deliberately broken windows in front of his parents, "deliberately worked himself into rages," melodramatically threatened his father with a sword, etc. All such behavior has been described as if it were nonconflictual and did not induce anxiety or guilt. These features led the parents to compare Ian with Mrs. F.'s "psychopathic" and often-institutionalized brother. Ian's behavior in treatment has illustrated, in minimal fashion, some of the characteristics the parents have alluded to, i.e., his slyness and manipulative provocations. Ian adds further support to this impression by purporting that he does things because he wants to be bad; i.e., he wishes me to believe that he is consciously controlling and directing his temper tantrums (which is highly questionable).

When this type of behavior is juxtaposed with the developmental

history of Ian's provocative attacks on older and larger boys and on his mother, one is left with a different impression, viz., that Ian feels impelled to precipitate trauma, which he is eternally expecting and fearing. The boy's aplomb after such incidents has the quality of a ritualized, parentally induced attempt to intellectualize or rationalize, to find reasons for behaviors and rages that are otherwise inexplicable. This is further complicated by Ian's unconscious sadism which colors his attacks. In this respect, he is aware of a partial truth, viz., that he does want to hurt, ravage, and revenge himself upon his parents.

The superego is fully structuralized, but is archaic in its sadism and intensity. The evidence for this statement is derived from several sources. Ian's reaction formations, his religious orientation and fears, the general adequacy of his moral values and standards, all are maintained independent of his parents or setting. Moreover, his depressed moods, his constant self-devaluation and sadistically cruel innuendoes as to self-damage and inadequacy indicate that aggression has been turned against the self (via the superego). The apparent lack of guilt in Ian may be explicable in terms of the parents' behavior; viz., their solicitation of Ian to confess his misdeeds so that they could mitigate his guilt. One suspects an externalization of the superego, in which the parents either absolve or punish him so that Ian escapes responsibility, anxiety, and guilt.

The developmental history is consistent with the view that structuralization occurred early, and self-control, via introjection, was an early and dramatic necessity for a child who seemed to have felt overwhelming concern both for his own rages and those of the environment.

C. *Internal Conflicts*

Ian has been a vigorously active child since birth. Whatever passive drive endowment he may have, it is little evident today, except perhaps in his symptom formation, e.g., in his dependent inability to separate from his parents at night. Ian's controlled activity has the hallmark of a defense against passivity and indicates a pathological resolution of his passive-active tendencies. Such attitudes are relatively age-adequate. The pathological implications

derive from the developmental history and the clear evidence that this boy has warded off passivity since earliest childhood.

His masculine-feminine conflicts are of a similar nature. Ian is a most "masculine" boy who permits himself few behavioral characteristics that might imply anything "girlish." He acknowledges that he sometimes cries to himself in despair and anger, but he considers this to be a bit "babyish" and not feminine. Ian's inability to sleep in the home and bedroom of school friends could reflect a defense against passive, feminine tendencies. While his father is a passive-appearing and gentle man, he is also as dynamically coiled and powerful as a steel spring. Ian emulates his father's silent superiority and strength, and shares with him a rather pious but implicitly contemptuous attitude toward girls and women. This attitude is age-adequate for Ian, and the pathological implications are inferred only from the implacability of defense.

VIII. Assessment of Some General Characteristics

A. *Frustration Tolerance*

The mother has always believed that Ian had little tolerance for frustration and cites his earliest screaming "until blue in the face" in illustration. While the dynamics of that particular parent-child interaction is suspect (e.g., the mother's intolerance of passivity), the history does suggest an early developmental impasse in which Ian did not have a gradual and easy introduction to frustrations that were within his capacities to cope. The mother seems to have been consistently unable to respond appropriately in gauging the child's capacities at each developmental level and she seems to have permitted excessive frustrations and then overindulged in compensation. Ian has developed a view according to which his tempers are all rages, his hungers are all famines, his loves are all passions, etc. He seems, unrealistically, to judge his needs as potentially overwhelming. Yet this overstates the problem, since Ian has established that he functions reasonably well in a benign atmosphere away from the parents. Moreover, the parents have also strongly suspected that Ian's tempers and allusions to his seizures may have a highly melodramatic undercurrent, and be used by him as a manipulative control of them.

It will be recalled that the father, in particular, has expected Ian to act like an adult, and Ian seems to have adopted this attitude with regard to his own behavior, particularly when he is away from home. Ian shows an age-adequate degree of frustration tolerance in postponing direct gratification, e.g., in deferring free play for hard and continuous practice in football games; saving pocket money for deferred plans in weeks to come; etc.

Frustration and anxiety tolerance are not always easy to distinguish. Moreover, Ian's frustration tolerance may have a masochistic quality, and some of his frustrations and suffering may be unnecessary. The boy seems to obtain a measure of self-esteem regulation in a stoic ideal of being strong and tough (perhaps like his father). He has coped most adequately in the area of his physical illnesses requiring many neurological examinations, orthodonture treatment, hospitalization and correction of hernia, etc. There is little question that he can and does cope with many more frustrations than most boys his age. His inability to cope in other areas and his "babyish" reactions to hurt and frustration have a regressive and neurotic coloring that is dramatic for its contrast with his otherwise excellent adequacy.

B. *Sublimation Potential*

Where Ian's psychopathology does not distort his perception, where the environment is benign, his progress seems to have been fairly constantly progressive. He has clearly demonstrated his capacity for displacement of drive energies, and his learning capacity is relatively free of id invasions. His work, however, seems relatively joyless; and his humor, when it emerges, is more often sadistic (practical jokes). His activities are controlled, competent, and "neutralized." Ian is capable of directing a considerable degree of psychological effort to secondary-process activity, but much of this leaves the impression of defensive activity.

The conceptual distinction between sublimation and the defense of displacement is not an easy one to make, particularly with the limited evidence available in the case of Ian. As Anna Freud (1948) has noted, when viewed from the side of the id, sublimation involves a displacement of sexual and aggressive energies to noninstinctual aims and implicitly involves a loss of pleasure. She also notes, how-

ever, that sublimation "brings great gains: the flow of instinctive energy into socially adapted behaviour widens the scope of the child's interests, transforms otherwise dull and uninteresting tasks into interesting and fascinating pursuits, and—as every teacher can observe—thereby improves the child's ability to work and play and quickens his intelligence" (p. 28). Robert Waelder (1964), commenting on Anna Freud's formulation, has noted that "all later papers by various authors emphasize merely the desexualization of the drive without noticing the concomitant sexualization of the respective ego activity. Thus, sublimation appears in these later publications as a net gain from the point of view of the ego; actually, the implicit sexualization of the ego entails the danger that the ego activity in question may be embroiled in the conflict to which the drive has been subject. The ego is somewhat in the position of a nation that has called on another nation for help—an action which may have its immediate rewards but also its perils; the ego has marshaled the mighty support of an instinctual drive, but that is not always a comfortable ally to have."

Ian's sublimation potential seems constantly threatened by contaminations of aggressive and sexual drives which he cannot adequately displace. This is evident in the boy's recurrent difficulties with schoolwork, in his need to isolate himself in social relationships, in his preoccupations with intellectual processes intimately connected with instinctual conflicts.

C. *Overall Attitude to Anxiety*

Both the parents and Ian indicate that he suffers and experiences little anxiety. The only indication that Ian might have such feelings concerns his abortive attempts to stay overnight in the homes of friends. He (blandly) told me that he was "panic-stricken." Yet his description of thoughts, feelings, and behavior during such occasions leaves doubt that he actually suffers much anxiety, as contrasted to that described by other patients. Rather, one gains the impression that Ian has scant tolerance for anxiety and defends himself phobically against any circumstance or situation in which anxiety might arise. He has been free to withdraw from most anxiety-producing situations, returning to his home and parents. There is some evidence that he resorts to obsessional rumination to handle anxiety

when either self-esteem or physical circumstance has limited the possibility of physical withdrawal. In his regressions to tantrum behavior at home, Ian does *not* give the impression of a child whose ego is completely wanting in intrinsic strength to cope with anxiety, but rather that his compliant and perhaps seductive environment has indulged him to such an extent that he has had little reason to cope with anxiety by means of internal resources.

D. *Progressive Forces versus Regressive Tendencies*

Ian's aggressive and defiant behavior at home, which brought him to treatment, has been seen by the parents as a regressive trend. Preliminary indications from the boy's treatment, however, indicate clearly that Ian had begun to withdraw from his mother's seductive and aggressive demands that he share his intimate secrets with her, that he confess, etc. He knew very well that his deviant tantrum behavior maneuvered his parents into a psychiatric referral for him. In a restrictive sense, such deviant behavior then constitutes a "progressive tendency," a use of acting out to precipiate outside intervention in a developmental impasse. This view is supported by Ian's enthusiastic response to his treatment. He has been quite concerned about his "babyishness," his inability to stay away from home. He has been even more concerned that he might be "mad" and beyond help. He is a hurt and lonely boy in search of better solutions. His regressive tendencies and family battles have been a way of life, providing both excitement and pleasure, yet this has not been totally syntonic for Ian. Large for his age, Ian is growing rapidly and already showing secondary sexual characteristics. His pubertal growth and concomitant sexual drive activity may facilitate progressive movement. But there is little question that Ian's psychopathology is most pronounced and that his defense organization is maladaptive and regressive.

IX. Diagnosis

The openness of Ian's aggression with his mother is understood as a peculiar derivative of his fixations, his neurotic conflict, and the mother's seductiveness. There is no evidence of atypical, borderline or psychotic impairment. While there is evidence of possible

organic complications, this does not imply a destructive, degenerative process that affects mental growth. One is impressed with the fact that Ian has a lot to cope with, both because of his fear of organic damage and because of the constant reality that he might have a seizure and that he must take anticonvulsant medications.

What seems to have been a psychoneurotic behavioral disorder of essentially oedipal nature has now settled into a less easily recognizable symptomatology. Ian's intense and sexualized tie to his mother (in particular) indicates a faulty resolution of his oedipal conflict. Ian's move into age-adequate latency is obviously hindered by his powerfully ambivalent ties to his mother; in addition, a secondary complication derives from his archaic superego which denies Ian pleasure in his achievements and demands punishments that infantilize and damage him. One also suspects that he has identified with the brain-damaged sister. Ian's infantile neurosis seems to be in the process of becoming encapsulated in a character disorder, in which there is ego-syntonic phobic avoidance of anxiety- or frustration-producing situations. The externalization of responsibility (superego) and the parents' readiness to justify and rationalize Ian's deviant behavior (as due to organic damage) have facilitated a beginning character structure that has the hallmarks of a delinquent or impulse disorder.

Psychotherapy has now continued for three months, with two sessions per week. Ian has settled into a secure and reasonably effective therapeutic relationship. His behavior in school and his academic performance are temporarily undisturbed, probably because he now studies in the school building, thereby neutralizing the mother's interventions. Ian's tics have (temporarily?) disappeared. Behavioral difficulties at home have markedly diminished but gradually begin to invade the treatment situation, where Ian likes to provoke, test, tease, etc. As one would expect, the emergence of these transference reactions has drained much of Ian's neurotic impulses to act out at home. The treatment problem becomes one of determining whether twice weekly treatment can control the development of negative transference aspects and permit sufficient intellectual insight so that at least some defensive readaptation might be accomplished. It seems highly questionable that the neurotic problem can be adequately worked through in nonintensive treatment,

which provides only a very limited possibility to break the circularity of parent-child excesses of overstimulation. At best, one would anticipate that progressive maturational forces (alone with nonanalytic treatment) might facilitate more effective encapsulation of the neurotic process.

Analysis would be the treatment of choice. Ian seems highly motivated and accessible to therapy. In considering analysis, his obsessive, ruminative insightfulness constitutes a resistance to treatment, but taken in conjunction with his excellent intelligence it is also an advantage.

The timing of this referral was not ill-advised. Ian presented the picture of a boy who was almost prepared to abandon his limited relationships with peers and the social standards which he had previously maintained effectively. For Ian, the danger seems to have been the extension of sadomasochistic battles with his parents to other relationships and the acceptance of such behavior as normal (epileptic), and approximating the behavior of his "psychopathic uncle."

The seizure condition and continuing heavy medication have undoubtedly put additional stress on Ian's strained resources. However, his difficulties do not date from his first seizure episode or from the increases in his medication. Rather, the developmental history gives clear clues as to the inception of difficulties, i.e., separation anxiety, with a persistent developmental impasse in the parent-child relationship. Even if medication could alleviate further seizures, the diagnostic picture is that of an encapsulated psychopathological debility which impairs the child's psychological functioning and potentials for emotional, sexual, and social development.

However clear the neurological diagnosis, the presenting symptoms are not incompatible (given the developmental history) with a hysterical exacerbation (if not hysterical origin) of a latent neurological dysfunction (Gottschalk, 1956). In this regard, one is reminded of Freud's observation that a patient's susceptibility to specific modes of tension discharge might well be based on prior illness that would lay down certain psychophysiological patterns. The introductory months of psychotherapy have made it clear that Ian is exceedingly concerned about his "damage." In this regard, whatever the boy's "seizure potential" may be, he suffers from a sense

of damage and a feeling of incapacity which has caused long-standing anxiety and is now an integral part of his neurotic problem.

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